2024 Flexible Benefits Plan *(Flexible Spending Accounts - FSA)*
Compensation Reduction Agreement

Name: _____ Last 4 of Social Security #: ___ ___ ___ ___

Address: _____

I choose to enroll for certain benefits under the:

___ **Medical Reimbursement Account (MRA)** – for medical, dental, vision, over-the-counter and prescription expenses and deductibles not covered by insurance, for you and your dependents but not for health insurance premiums.
I elect to receive the benefits provided to me under the MRA by reducing my compensation by **$_____** per pay period (minimum of $20), but in no event shall my total compensation reduction for the year exceed the maximum benefit amount permitted ($3,200 maximum.)

___ **Dependent/Child Care Assistance Plan (DCAP)** – for dependent/child care related expenses.
I elect to receive the benefits provided to me under the DCAP by reducing my compensation by **$_____** per pay period (minimum of $20), but in no event shall my total compensation reduction for the year exceed the maximum benefit amount permitted ($5,000 maximum.)

I understand that:

- My employer and I agree that my compensation will be reduced, subject to the maximum benefit amount set forth above, and shall continue for each succeeding pay period until this agreement is changed or revoked, or until I reach my maximum benefit amount as set for above.
- I cannot change or revoke this benefit election or Compensation Reduction Agreement as of any date prior to the next January 1st, unless I terminate my employment with my employer, or I have a "major life event" (i.e. marriage or divorce of employee, death of a spouse or dependent of employee, birth or adoption of a child by employee, termination or commencement of employment of a spouse, switching from part-time to full-time or from full-time to part-time employment status by employee or spouse, taking an unpaid leave of absence by the employee or spouse, and any event which the Plan Administrator deems to be a change in the family status of the participant and which is consistent with Section 125 of the Internal Revenue code and regulations.)
- The change or revocation of this Compensation Reduction Agreement based on a change in family status is allowable only if it is consistent with the particular change in family status.
- Prior to January 1st each year, I will be offered the opportunity to change my benefit election(s) for the following Plan Year. If I do not complete and return a new enrollment form at that time, I will be treated as electing to receive my full compensation in cash in lieu of such coverage under the Flexible Benefits Plan for the new Plan Year (January 1st to December 31st).
- The Plan Administrator may reduce or cancel the amount of my compensation reduction or otherwise modify this Compensation Reduction Agreement in accordance with the provisions of the Flexible Benefits Plan if it believes it is advisable in order to satisfy certain provisions of the Internal Revenue Code.
- The reduction in my cash compensation under this Compensation Reduction Agreement will be in addition to any reductions under other agreements or benefit plans.
- This benefit election will automatically be canceled as of the date of my termination of employment.
- Any amount(s) not used for eligible expenses incurred during the plan year remaining in these accounts after the filing claim period will be **forfeited** in accordance with current plan provisions and tax laws.
- I certify the above information to be correct and true to the best of my knowledge.

Accepted and agreed to:

_____ _____
Signature of Employee Date

_____ _____
Signature for Employer Date

Plainville Community Schools
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